APPLICATION FOR APPN LICENSURE
HOLDS COMPACT RN LICENSE

Use this application if:

The applicant lives in a Compact State

An Idaho APPN license has never been issued previously

See Application for Prescriptive and Dispensing Authorization for prescriptive authority.

Criminal Background checks – Fingerprint-based are required for all applicants. Cards are available from the Board office. See item "Fingerprint Card – Related Fees"

APPLICATION INSTRUCTIONS FOR ADVANCED PRACTICE PROFESSIONAL NURSES
NURSE LICENSURE - COMPACT STATE RESIDENT

This application may be used by nurses applying for licensure as an advanced practice professional nurse (CNM, CNS, NP, RNA). ***NOTE: If you are applying for advanced practice licensure and are currently licensed as a professional nurse (RN) and are residing in a State that has adopted the Nurse Licensure Compact (Arizona, Arkansas, Delaware, Iowa, Maine, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, or Wisconsin), you do not need to apply for an Idaho professional nurse (RN) license in addition to your APPN license.***

The following must be on file with the Board of Nursing in order to determine your eligibility for APPN licensure in Idaho. Documents requiring notarization may NOT be received by FAX. (All documents become the property of the Board and may be destroyed, without further notification, if the application is not completed within one year.)

1. **APPLICATION FORM:** Only application forms provided by the Board, completed in ink and notarized will be accepted. Photocopies or faxed copies of application forms will not be accepted.
   1) If all information requested is not supplied, provide an explanation for the omission.
   2) Sign the affidavit with your usual signature and have it notarized.
   3) Attach a 2 x 2 identification photograph, taken within the last year. Electronically scanned photos are not acceptable; features must be clearly identifiable. Black & white or color photos are acceptable.
2. **FEE.** Enclose the appropriate fee:
   Advanced Practice Professional Nurse (CNM, CNS, NP, RNA) - $90.00
   APPN Temporary License (available upon request) – No Fee
3. **CENSUS QUESTIONNAIRE**: Complete the enclosed Census Questionnaire and return with your completed application.
4. **OFFICIAL TRANSCRIPT:** Request an OFFICIAL TRANSCRIPT indicating completion of an Advanced Practice Professional Nursing education program. The transcript must be mailed directly to the Board of Nursing office by the granting institution.
5. **RN LICENSE.** Attach a copy of your current RN license in a Compact state to the enclosed affidavit.
6. **ADVANCED PRACTICE PROFESSIONAL NURSE NATIONAL CERTIFICATION**. Attach a copy of your current certificate to the enclosed affidavit.
7. **DECLARATION OF STATE OF RESIDENCE**. Complete the enclosed form attesting that your primary residence is in a Compact state.
8. **FINGERPRINT CARD**. Complete the required Fingerprint card and submit to the Board for processing. Only cards from the Board office are acceptable **- fee for processing - $34.00.**

INSTRUCTIONS FOR TEMPORARY LICENSURE

Advanced practice professional nurse applicants (CNM, CNS, NP, RNA) applying for APPN temporary licensure, who reside in and are currently authorized to practice in a Compact state must submit the completed application form and the "Affidavit Attesting to Validity of Copy", attached item 1 or 2:

1) A copy of your current national certification certificate showing the expiration date. NOTE: If you have not yet taken the certification examination, submit a copy of the document, which verifies acceptance to take the examination; or
2) If your national certification has lapsed, submit a copy of your lapsed certificate. The Board will consider issuance of a conditional temporary license in order for you to meet specified practice requirements for re-entry into advanced practice professional nursing, and
3) Official transcript. If a final transcript is not yet available, submission of one of the following documents is acceptable:
   a. Correspondence received directly (by FAX or mail) from the administrator of the educational program attesting to completion of all graduation requirements; or
   b. Notarized copy of diploma.

PLEASE BE ADVISED: Advanced Practice Professional Nurses must renew their license(s) by August 31st of every odd-numbered year. A nurse who applies for licensure on or after March 1st of the year, in which the license would ordinarily be renewed, will be issued a license valid until the next renewal period.

IDAHO BOARD OF NURSING - PO BOX 83720 - BOISE, ID 83720-0061
(208) 334-3110
APPLICATION FOR NURSE LICENSURE

For Office Use Only

License #_____
APPN #_____
Receipt#_____
Amount _____
Approval
Temp_____
Licensure_____

Check **all** categories for which application is being made:

- ☐ **Licensed Practical Nurse (LPN)**
  - ○ Licensure by Endorsement
  - ○ Licensure by Reinstatement
- ☐ **Licensed Professional Nurse (RN)**
  - ○ Licensure by Endorsement
  - ○ Licensure by Reinstatement
- ☐ **Advanced Practice Professional Nurse**
  - ○ Certified Nurse-Midwife
  - ○ Clinical Nurse Specialist
  - ○ Nurse Practitioner
  - ○ Registered Nurse Anesthetist
- ☐ **Temporary Licensure**

AFFIX A 2" X 2"
PHOTOGRAPH
HEAD AND SHOULDERS ONLY
Taken within the Year
DO NOT STAPLE

Date of photo_____

Name_____
Last First Middle Maiden
Other names used previously_____

Mailing Address_____
City State Zip Code
Telephone - Home: ( )_____Work: ( ) _____ S.S. No. _____

Birthplace_____Birth Date_____
(City & State) (Mo/Day/Year)

BASIC RN/LPN EDUCATION

Name of Practical Nursing (LPN) Education Program _____

Location_____

Month/Year Graduated_____Type of Degree/Credential_____

Name of Professional Nursing (RN) Education Program_____

Location_____

Month/Year Graduated_____Type of Degree/Credential_____

LICENSURE

1. Have you ever taken the State Board Test Pool Examination (SBTPE) or National Council Licensure Examination (NCLEX) in any state of the United States? ☐ Yes ☐ No ☐ RN ☐ PN
2. Have you ever been licensed or made application for licensure as an RN/LPN/APPN in Idaho prior to this date? ☐ Yes ☐ No
   If previous Idaho licensure, indicate year and name used_____
3. State and year of original RN/LPN licensure_____ License No._____
4. List all states in which you are or have ever been licensed_____
   _____

YOU MAY NOT PRACTICE NURSING IN IDAHO AS DEFINED IN THE NURSING PRACTICE ACT, IDAHO CODE, SECTION 54-1401 THROUGH 54-1417, UNTIL YOU HAVE FILED AN APPLICATION AND RECEIVED A TEMPORARY OR RENEWABLE LICENSE.

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EMPLOYMENT INFORMATION

LIST LAST THREE (3) YEARS OF NURSING EMPLOYMENT: (Additional information may be listed on a separate sheet.)

Name & Complete Address of Employer	Position	Employment From	Employment To

If you have not been employed in nursing within the last three years, or if there are gaps in employment, indicate your **last year of nursing employment** and explain the reason. (Supervised practice and a content update may be required if you have not engaged in nursing practice during the last three years.)_____

_____

IT IS THE DUTY OF EACH APPLICANT TO MAKE INQUIRY OF THE INDIVIDUAL LICENSING BOARDS REGARDING THE STATUS OF LICENSURE IN THAT STATE BEFORE RESPONDING TO THE QUESTIONS BELOW. Ignorance of license status or disciplinary information will not constitute an excuse for incorrect information. In addition, failure to disclose all licenses may result in denial of your application or other appropriate action.

SCREENING QUESTIONS

PLEASE ANSWER ALL QUESTIONS (For all "yes" answers, attach a complete explanation including dates, circumstances and supporting documents if necessary.)

1.	Has your nursing license ever been disciplined in any state (e.g., revoked, suspended, placed on probation, formally reprimanded, or otherwise encumbered)?		☐Yes ☐No
2.	Is any action pending against your nursing license in any state?		☐Yes ☐No
3.	Have you ever had approval to practice in an advanced role denied, limited, suspended, revoked or otherwise disciplined?	☐NA	☐Yes ☐No
4.	Have you ever had an application for nursing license denied?		☐Yes ☐No
5.	Have you ever been denied admission to take a nursing examination by any state?		☐Yes ☐No
6.	Do you have, or have you been diagnosed as having, or have you been treated for having a physical or mental condition, including drug or alcohol addiction during the past five (5) years, which may impair your ability to practice nursing with reasonable skill and safety?		☐Yes ☐No
7.	If yes, do you require special accommodations in order to practice?	☐NA	☐Yes ☐No
8.	Do you currently have any felony or misdemeanor charges pending against you in any jurisdiction?		☐Yes ☐No
9.	Have you ever pled guilty, entered a plea of nolo contendre, been convicted of, or received a withheld judgment for a misdemeanor or felony in any jurisdiction?		☐Yes ☐No

THE AFFIDAVIT BELOW MUST BE COMPLETED IN ORDER FOR YOUR APPLICATION TO BE VALID.

A F F I D A V I T

State of _____)
) s.s.
County of _____)

I,_____being duly sworn, declare that I understand the instructions and terms as set forth in this application form, that I am the person referred to in the foregoing application and this affidavit, and that I have personally completed this form, and that the information given in this application is true, correct and complete. I declare that I have no mental or physical disabilities (except as otherwise noted above) that presently interfere with my ability to competently and safely practice nursing and that I have read and understand this affidavit.

_____
Signature of Applicant

On this _____ day of _____, in the year of _____before me _____, notary public, personally appeared _____known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

_____

WITNESS my hand and official seal. My Commission expires_____

The following must be completed by Advanced Practice Professional Nurses applying for licensure in the categories of Certified Nurse-Midwife, Clinical Nurse Specialist, Nurse Practitioner or Registered Nurse Anesthetist.

ADVANCED PRACTICE PROFESSIONAL NURSE EDUCATION *

* Official Transcript is required and must be mailed by the granting institution directly to the Board of Nursing.

Please ☑ the category for which you are applying for licensure:

☐ **Certified Nurse-Midwife**: Name of Nurse-Midwifery Program:_____

Location of Program:_____

Dates Attended:_____ Degree/Credential_____

☐ **Clinical Nurse Specialist**: Name of Graduate Nursing Program:_____

Location of Program:_____

Dates Attended:_____ Degree/Credential_____

☐ **Nurse Practitioner**: Name of Nurse Practitioner Program:_____

Location of Program:_____

Dates Attended:_____ Degree/Credential_____

☐ **Registered Nurse Anesthetist**: Name of Nurse Anesthesia Program:_____

Location of Program:_____

Dates Attended:_____ Degree/Credential_____

ADVANCED PRACTICE PROFESSIONAL NURSE CERTIFICATION

APPN Certification:

Name of certifying organization:_____

Date of original certification:_____

If not yet certified, date scheduled for examination_____

A notarized copy of your current certificate, or a document which verifies acceptance to take the examination must be enclosed.

IDAHO BOARD OF NURSING

Professional Nurse (RN)
2005-2007 CENSUS QUESTIONNAIRE

For Office Use Only

Cert #_____
Rec't #_____Amt_____
Date Issued_____
☐ Reinstatement
☐ Endorsement

Please Print

NAME :_____

ADDRESS :_____

CITY & STATE :_____

Zip Code

Idaho License No.	Birth Date	Social Security No.	Gender* (Optional)	County Name	
	/ /	- -		Residence:	Employment:

Ethnicity* (Optional) ☐ Caucasian(1) ☐ African American/Black(2) ☐ Hispanic(3) ☐ Am. Indian/Alaska Native(4)
☐ Asian/Pacific Islander(5) ☐ Multi-Racial(6) ☐ Other(99)_____

(*Voluntary disclosure information – response optional)
Please choose only one answer for each question, write the appropriate number in the box to the left.

EMPLOYMENT STATUS	1. Employed in nursing full-time 2. Employed in nursing part-time 3. Employed outside nursing 4. Not Employed/Seeking Employment	5. Not Employed/Student 6. Not Employed/Not Seeking 7. Volunteer 8. Emeritus	9. Retired
PRIMARY EMPLOYER	Employer_____ Address_____		
PRIMARY EMPLOYMENT	1. Hospital 2. Nursing Home 3. Home Health/Hospice 4. Public Health 5. Occupational Health 6. Medical Office/Clinic	7. Assisted Living 8. Nursing Education 9. Insurance Company 10. Jail/Prison 11. School Health 12. Outpatient Facility	99. Other (specify) _____
TYPE OF POSITION	1. Staff or General Duty 2. Case Manager/Discharge Planner 3. Administrator/Supervisor 4. Educator 5. Advanced Practice (not RN Specialty)	6. Quality Assurance/Outcomes Management 7. Consultant/Researcher 8. Charge/Lead Nurse/ Team Leader 99. Other (specify)_____	
MAJOR CLINICAL AREA	1. Geriatric 2. Gynecologic/Obstetric 3. Medical/Surgical 4. Pediatric	5. Psychiatric/Mental Health 6. Emergency 7. Community/Public Health 8. Rehabilitation/Restorative	99. Other (specify) _____
BASIC EDUCATION	1. Diploma 2. Associate Degree	3. Baccalaureate Degree or Higher 4. Other (specify)_____	
HIGHEST DEGREE	1. Diploma/RN 2. Associate Degree/RN 3. Baccalaureate Degree/RN 4. Baccalaureate Degree in Other Field (specify)_____ 5. Masters in Nursing	6. Masters in Other Field (specify)_____ 7. Doctorate in Nursing 8. Doctorate in Other Field (specify)_____ 9. PN Certificate/Diploma	10. PN Associate Degree 99. Other (specify) _____

Year Advanced Degree was Granted_____

I am currently taking courses toward an additional/advanced degree in nursing? ☐ Yes ☐ No
I intend to leave/retire from the practice of nursing in the next two years? ☐ Yes ☐ No
States other than Idaho in which I am practicing:_____

Information provided is for statistical purposes only.

AFFIDAVIT ATTESTING TO VALIDITY OF COPY

I hereby certify that the attached is a direct photocopy of:
Please ☒ appropriate box (es).

- ☐ The certificate which shows proof of current licensure as a licensed professional nurse (RN)
- ☐ The certificate which shows advanced practice professional nurse national certification
- ☐ The document which verifies acceptance to take the certification examination
- ☐ The diploma from my Advanced Practice Professional Nurse educational program

Total number of documents_____ _____
Signature of Applicant

On this _____ day of _____, in the year of _____, before me _____, a notary public, personally appeared _____, known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

(Notary Seal) _____
Notary Public

_____
My Commission Expires

AFF APPN 2001

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The following items must be submitted when you file your application for **APPN** licensure:

- ☐ Completed, notarized application – pages 1, 2 **and** 3.
- ☐ Fee – for Advanced Practice Professional Nurse licensure
- ☐ Declaration Form
- ☐ Affidavit attesting to the Validity of Copies – attach a copy of your RN license and APPN Certification card
- ☐ Fingerprint Card

Be sure that you have requested that an **OFFICIAL TRANSCRIPT** of your advanced practice professional nursing program be submitted directly to the Board office.